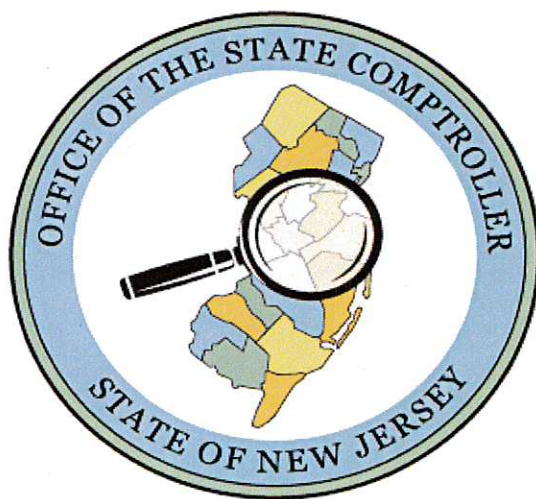


**STATE OF NEW JERSEY
OFFICE OF THE STATE COMPTROLLER
MEDICAID FRAUD DIVISION**

**BI-ANNUAL REPORT OF AUDIT
FINDINGS AND RECOMMENDATIONS
AND SETTLEMENTS**



Reporting Period: January 1, 2018 through June 30, 2018

**Philip James Degnan
STATE COMPTROLLER**

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I. THE OFFICE OF THE STATE COMPTROLLER'S MEDICAID FRAUD DIVISION

The Office of the State Comptroller, Medicaid Fraud Division (MFD) serves as the state's independent watchdog for New Jersey's Medicaid, FamilyCare and Charity Care programs and works to ensure that the state's Medicaid funds are being spent effectively and efficiently. As part of its oversight role, MFD conducts audits and investigations of health care providers, managed care organizations and Medicaid recipients to identify and recover improperly expended Medicaid funds, and to ensure that only those who are eligible are enrolled in Medicaid.

II. REPORTING REQUIREMENTS

Pursuant to *N.J.S.A. 30:4D-60*, MFD is required to report the findings of its audits and investigations and recommendations for corrective action to the Governor, the President of the Senate and the Speaker of the General Assembly, and to the entity at issue. That statutory section further requires MFD to provide periodic reports to the Governor. To provide an overview of its other audits and investigations, MFD now respectfully submits this Bi-Annual Report of Audit Findings and Recommendations and Settlements made during the third and fourth quarters of Fiscal Year 2018.

During the third and fourth quarters of Fiscal Year 2018, through its audits and investigations, MFD identified approximately \$945,000 that is to be paid back to the Medicaid program.

III. SUMMARIES OF AUDIT FINDINGS AND RECOMMENDATIONS

MFD issued two audit reports of Medicaid providers during the third and fourth quarters of Fiscal Year 2018. Collectively, these audits identified approximately \$15,000 in improperly expended Medicaid funds that the audited providers are required to pay back to the Medicaid program. As with many audits, each of the providers audited submitted a Corrective Action Plan to ensure its ongoing compliance with federal and state Medicaid laws and regulations. The findings and recommendations for each of these audits is summarized below and copies of the official audit reports are included in the attached appendix.

WeCare Home Care Inc.

MFD and Amerigroup New Jersey Inc. conducted a joint audit of WeCare Home Care Inc. of Cherry Hill, N.J., specifically reviewing its billing for in-home personal care assistant services. Amerigroup New Jersey is one of five Managed Care Organizations that provide Medicaid services under a contract with the New Jersey Department of Human Services, Division of Medical Assistance and Health Services.

Auditors reviewed a statistically-valid sample of 111 filed claims and found that 26 of these claims failed to comply with state or federal regulations for Medicaid reimbursement. WeCare Home Care received a total of \$3,580.75 in Medicaid reimbursement for the 26 claims.

The error rate for the audited claims was extrapolated to include the total population of claims from which the 111 claims were drawn, resulting in a total overpayment of \$10,084 to WeCare Home Care.

WeCare Home Care agreed with the findings of the audit and agreed to reimburse the Medicaid program \$10,084. The provider has also submitted a Corrective Action Plan to ensure future compliance with Medicaid regulations.

Health and Comfort Home Care Agency

MFD and WellCare Health Plans conducted a joint audit of Health and Comfort Home Care Agency of North Brunswick, N.J., to determine whether the firm properly billed for in-home personal care assistant services. WellCare Health Plans is one of five Managed Care Organizations that provide Medicaid services under a contract with the New Jersey Division of Medical Assistance and Health Services.

Auditors examined 798 claims submitted by Health and Comfort Home Care Agency and found that 60 of these claims did not meet state or federal regulations for Medicaid reimbursement. The resulting overpayments totaled \$4,648.

Health and Comfort Home Care Agency agreed with the findings of the audit and agreed to reimburse the Medicaid program \$4,648. It has also submitted a Corrective Action Plan to ensure compliance with Medicaid regulations.

IV. SETTLEMENTS

During the reporting period, MFD staff also identified and investigated for potential fraud, waste or abuse numerous health care providers who provided goods and/or services to Medicaid beneficiaries throughout New Jersey. As a result of these efforts, MFD reached settlements through which providers agreed to reimburse approximately \$930,000 to the Medicaid program.¹ These settlements are listed below:

<i>Provider</i>	<i>Settlement Amount</i>
Dr. Sayed Aly (Bayonne, N.J.)	\$44,879
Newark Community Pharmacy (Newark, N.J.)	\$129,975

¹ Some of these settlements may have been separately reported through press releases during this time period.

<i>Provider</i>	<i>Settlement Amount</i>
Park Drugs (Linden, N.J.)	\$94,449
M&S Psychotherapy and Counseling (Clifton, N.J.)	\$73,461
Udoka Ejiofor/Luminous Cares (East Orange, N.J.)	\$90,000
Visiting Nurse Association Health Group (Holmdel, N.J.)	\$13,063
Dr. Mordecai Liechtung/Bright Smile (Neptune, N.J.)	\$73,206
Shayona Pharmacy (Perth Amboy, N.J.)	\$23,000
Dr. Beatrice Onyeador (Clifton, N.J.)	\$50,000
Just Home Adult Medical Day Care (East Brunswick, N.J.)	\$96,249
Dr. Raul Almanzar/Passaic Pediatrics II (Passaic, N.J.)	\$91,222
Special Care OB/GYN (Belleville, N.J.)	\$150,000



State of New Jersey

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

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MEDICAID FRAUD DIVISION
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PHILIP JAMES DEGNAN
State Comptroller

JOSH LICHTBLAU
Director

April 6, 2018

BY ELECTRONIC AND CERTIFIED MAIL

Mr. Jose M. Brito, Administrator
WeCare Home Care, Inc.
811 Church Rd., Suite. 221
Cherry Hill, NJ 08002

RE: Final Audit Report: WeCare Home Care, Inc.

Dear Mr. Brito:

As part of its oversight of the Medicaid and New Jersey FamilyCare program (Medicaid), the New Jersey Office of the State Comptroller, Medicaid Fraud Division (OSC) conducted an audit of claims billed under Healthcare Common Procedure Coding System (HCPCS) code S9122 and paid to your facility. The period of review was January 1, 2013 through December 31, 2014. OSC hereby provides you with this Final Audit Report (FAR).

Executive Summary

OSC, in conjunction with Amerigroup New Jersey, Inc. (Amerigroup), conducted a joint audit of WeCare Home Care, Inc. (WCHC) to determine whether WCHC appropriately billed for personal care assistant (PCA) services in accordance with applicable state and federal laws and regulations. More narrowly, the audit sought to determine whether WCHC correctly billed HCPCS code S9122, which is used to seek reimbursement for one hour of in-home PCA services. Based on the audit, OSC determined that 26 of the 111 statistically selected claims for HCPCS code S9122 totaling \$3,580.75 in reimbursements to WCHC failed to comply with state and federal requirements. Specifically, OSC found that WCHC failed to: a) complete timely in-home evaluations of the plan of care and/or completed invalid in-home evaluations for 16 claims; b) substantiate services billed for five claims; c) maintain a valid physician's order for four claims; and, d) document services billed for one claim.

For purposes of ascertaining a final recovery amount, the error rate for claims that failed to comply with state and federal regulations was extrapolated to the total population of claims from which the sample claims were drawn, which in this case was 877 claims with a total amount of payment of \$50,305. By extrapolating to this universe of

claims/reimbursed amount, OSC has determined that the total dollar amount of improper claims is \$10,084.

Background

The United States Department of Health and Human Services, Office of Inspector General (OIG) issued audit reports in December 2011, July 2015, and August 2015 focusing on New Jersey Medicaid's PCA program. In these reports, OIG found that New Jersey paid for certain Medicaid claims that did not comply with state and federal regulations. As part of these audits, OIG recommended that the New Jersey Department of Human Services (DHS) improve its monitoring efforts of the PCA program to ensure compliance with state and federal requirements.

The Division of Medical Assistance and Health Services (DMAHS), within the DHS, administers New Jersey's Medicaid program. Medicaid is a program through which individuals with disabilities and/or low income may receive medical assistance. DMAHS contracts with five Managed Care Organizations (MCOs), including Amerigroup, to provide healthcare services to New Jersey's Medicaid population.

OSC and Amerigroup conducted a joint audit of WCHC, a PCA/Homemaker service provider located in Cherry Hill, New Jersey. WCHC enrolled in the Medicaid program on July 1, 2009. WCHC provides services such as personal care, household duties, and health-related tasks in a recipient's place of residence.

Objective

The objective of this audit was to evaluate WCHC's PCA claims for HCPCS code S9122 billed to and paid by Amerigroup to determine whether WCHC complied with Medicaid requirements under state and federal laws and regulations.

Scope

The scope of this audit included a review of paid and adjusted claims billed to Amerigroup under HCPCS code S9122 for the period January 1, 2013 through December 31, 2014. The audit was conducted under the authority of *N.J.S.A. 52:15C-23* and the Medicaid Program Integrity and Protection Act, *N.J.S.A. 30:4D-53 et seq.*

Audit Methodology

OSC's audit methodology consisted of the following:

- Review of a statistically valid sample of 111 claims totaling \$12,702 selected from a population of 877 claims totaling \$50,305 that WCHC billed under HCPCS code S9122 and submitted for payment to Amerigroup; and

- Review of WCHC's clinical records to determine whether: PCA services were rendered; PCA services were authorized by the attending physician; PCA services were prior authorized by Amerigroup; a Registered Nurse conducted an in-home evaluation of the plan of care at a minimum of once every 60 days; and PCA services were rendered by licensed providers, and by providers not excluded/debarred from the Medicaid program.

Audit Findings

In-Home Evaluation of Plan of Care Not Timely Performed or Invalid

OSC reviewed the clinical records for the 111 sample claims to determine whether WCHC completed the in-home evaluation of the plan of care at least once every 60 days. OSC found that 16 of the 111 sample claims failed because WCHC's records did not show that WCHC had satisfied this in-home plan of care evaluation requirement. Four of these claims failed because the in-home evaluation of the plan of care was not completed within 60 days of the date of service. The remaining 12 claims failed because they were associated with in-home evaluations of the plan of care that were not completed on valid dates. For example, one record pertaining to the in-home evaluation of the plan of care was dated February 31, which is not a valid date. Timely completion of the in-home evaluation of the plan of care is required to ensure the plan of care is appropriate and to see if any changes are necessary. Since a recipient's needs may change, the plan of care may need to change as well.

Pursuant to *N.J.A.C. 13:45B-14.9(2)(g)*, "the health care practitioner supervisor shall make an on-site, in-home evaluation of the plan of care not less than once during each 60 day period during which the agency has placed or referred a health care practitioner in the home care setting." In accordance with *N.J.A.C. 10:49-5.5(a)(17)*, services that are not covered by the Medicaid program include, "services, goods or supplies which are furnished, rendered, prescribed or ordered in violation of federal or state civil or criminal statutes, or in violation of licensure statutes, rules and/or regulations." Also, in accordance with *N.J.A.C. 10:49-9.8(a)*, "providers shall certify that the information furnished on the claim is true, accurate, and complete."

Unsubstantiated Services Billed

OSC reviewed the clinical records for the 111 sample claims to determine whether the services that WCHC billed to Amerigroup were rendered. To make this determination, OSC compared the number of hours billed according to the assignment sheet (timesheet) to WCHC's paid claims data. OSC found that for 5 of the 111 sample claims, WCHC billed for more hours of service than were rendered on the dates of service based on WCHC's timesheets. Providers are required to bill and submit claims based on true, accurate and complete information.

Pursuant to *N.J.A.C. 10:49-9.8(a)*, "providers shall certify that the information furnished on the claim is true, accurate, and complete."

Valid Physician Order Not Maintained

OSC reviewed the clinical records for the 111 sample claims to determine whether services were authorized for the recipient by a physician's order that was signed and dated by the physician. OSC found that in 4 out of the 111 claims sampled, the physician did not date the physician's order. A properly dated physician's order is necessary so that caregivers understand the nature and extent of services that are to be provided at a specific time. If a physician's order is not dated, it is difficult to ensure that proper services are being provided as a recipient's needs are subject to change.

Pursuant to 42 CFR 440.167(a), PCA services are "services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease." The services are "authorized for the individual by a physician and in accordance with a plan of treatment." In accordance with N.J.A.C. 10:49-5.5(a)(17), services that are not covered by the Medicaid program include, "claims for services, goods or supplies which are furnished, rendered, prescribed or ordered in violation of federal or state civil or criminal statutes, or in violation of licensure statutes, rules and/or regulations." Also, in accordance with N.J.A.C. 10:49-9.8(a), "providers shall certify that the information furnished on the claim is true, accurate, and complete."

Undocumented Services

OSC reviewed the clinical records for the 111 sample claims to determine whether services that WCHC provided were adequately documented in the medical record. OSC found that 1 of the 111 sample claims did not meet the appropriate documentation requirements. Specifically, for one of the sample claims there was no assignment sheet (timesheet) in the medical record. Assignment sheets not only ensure that services were rendered to the recipient but also validate that services were in fact received by the recipient.

Pursuant to N.J.A.C. 10:49-9.8(b)(1), providers are required "to keep such records as are necessary to disclose fully the extent of services provided."

Summary of Overpayments

Based on its review, OSC determined that 26 of the 111 sample WCHC claims for Medicaid reimbursement failed to comply with state and federal regulations. WCHC received a total of \$3,580.75 in reimbursement for these 26 claims. For purposes of ascertaining a final amount of overpayment in this audit, the error rate for claims that failed to comply with state and federal regulations was extrapolated to the total population from which the sample claims were drawn, which in this case was 877 claims with a total amount of payment of \$50,305. On this basis, OSC has determined that WCHC received an overpayment totaling \$10,084.

Recommendations

OSC recommends that WCHC reimburse Medicaid the overpayment amount, which is \$10,084. Also, OSC recommends that WCHC prepare a Corrective Action Plan (CAP) informing OSC of the procedures it will undertake to correct the deficiencies identified in this report. As part of its CAP, WCHC must provide training to its staff to foster compliance with applicable Medicaid regulations, specifically those regarding Medicaid program documentation.

Auditee Response

In a written response, WCHC agreed with the audit findings and provided a CAP to address the audit's recommendations. WCHC also described the specific steps they have taken or will take to implement the recommendations made in this audit report. The full text of the response letter submitted by WCHC is included as an Appendix to this report.

OSC Comments

OSC notes that WCHC is in complete agreement with the audit's findings and recommendations. Accordingly, OSC requests that WCHC reimburse the Medicaid program \$10,084 and that it implement the corrective actions needed to comply with the recommendations in this audit. Given WCHC's agreement with the findings in this audit and its stated intention to implement corrective actions, OSC believes that no further action is necessary with respect to this audit.

Sincerely,

PHILIP JAMES DEGNAN
STATE COMPTROLLER

By:


Josh M. Blum, Director
Medicaid Fraud Division

Cc: Veronica Scott, Manager, Special Investigations Unit (Amerigroup)
Kay Ehrenkrantz, Deputy Director
Don Catinello, Supervising Regulatory Officer
Glen Geib, Recovery Supervisor

Appendix



4/2/2018

To whom it may concern:

This letter is to inform you, that we are in agreement with the findings of the Audit of the Medicaid Fraud Division. After carefully reviewing all findings in the report, we have concluded that there were some flaws in our system due to human error rather than fraudulent intent; these errors did not occur with a deliberated intent to increase any reimbursement or financial gains.

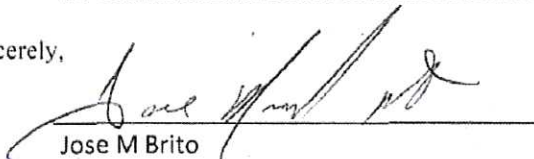
WeCare Home Care, Inc. is working aggressively to correct these findings, and will put in place a more stringent procedure to assure that we are in compliance, so these errors do not happen again going forward. Moreover, we are working closely with our Software vendor called Home Care System, Inc. to improve our computer system to avoid any erroneously dated document and incorporate additional reports to include any future missing documents.

As part of our corrective Action Plan, WeCare will address these errors by the following:

- A) For the in home evaluation Plan of Care, we will assign a fact checker from our current personnel to eliminate any invalid dates or missing information.
- B) We are upgrading our billing software to insure the proper billing that will alert us any possible error.
- C) Our computer software will be update to include a report for future physician orders prior to its yearly expiration.
- D) Finally WeCare will improve its filing system, by re-training our personnel regarding the guidelines of Medicaid Program documentation. Furthermore, to make sure that all services rendered and billed will be properly documented.

We considered this audit as teachable event that will enhance our future compliance to Medicaid, and

Sincerely,



Jose M Brito
President/CEO

WeCare Home Care, Inc

811 Church Rd suite # 221

Cherry Hill, NJ 08002

Phone: 856 283 4080

Fax: 856 673 1905

1 800 654 0914

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State of New Jersey

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PHILIP JAMES DEGNAN
State Comptroller

JOSH LICHTBLAU
Director

June 15, 2018

BY ELECTRONIC MAIL AND CERTIFIED MAIL

Mr. William Miska, Managing Member
C&M Health Services LLC d/b/a
Health and Comfort Home Care Agency
1254 Highway 27
North Brunswick, NJ 08902-1765

RE: Final Audit Report: Health and Comfort Home Care Agency

Dear Mr. Miska:

As part of its oversight of the Medicaid and New Jersey FamilyCare program (Medicaid), the New Jersey Office of the State Comptroller, Medicaid Fraud Division (OSC) conducted an audit of claims billed under Healthcare Common Procedure Coding System (HCPCS) codes S9122, S5130, and T1019 and paid to your facility. The period of review was July 1, 2014 through December 31, 2014. OSC hereby provides you with this Final Audit Report (FAR).

Executive Summary

OSC, in conjunction with WellCare Health Plans (WellCare), conducted a joint audit of Health and Comfort Home Care Agency (HCHC) to determine whether HCHC appropriately billed for personal care assistant (PCA) services in accordance with applicable state and federal laws and regulations. More narrowly, the audit sought to determine whether HCHC correctly billed HCPCS code S9122 (PCA services provided in home, per hour), S5130 (PCA services provided in home, per 15 minutes) and T1019 (PCA services provided in home, per 15 minutes), which are used to seek reimbursement for in-home PCA services. Based on the audit, OSC determined that 60 of the 798 claims for HCPCS code S9122 and T1019 totaling \$4,648.40 in reimbursements to HCHC, failed to comply with state and federal regulations. Specifically, OSC found that HCHC failed to: a) bill claims which were true and accurate as they billed claims twice for the same service for the same recipient on the same day, once using HCPCS code S5130 and once using HCPCS code S9122 for 36 claims; b) maintain a valid physician's order for 12 claims; c) substantiate services billed for six claims; d) complete timely in-home evaluations of the

plan of care for five claims; and, e) document services billed for one claim. OSC has determined that the total dollar amount of improper claims is \$4,648.40.

Background

The United States Department of Health and Human Services, Office of Inspector General (OIG) issued audit reports in December 2011, July 2015, and August 2015 focusing on New Jersey Medicaid's PCA program. In these reports, OIG found that New Jersey paid for certain Medicaid claims that did not comply with state and federal regulations. As part of these audits, OIG recommended that the New Jersey Department of Human Services (DHS) improve its monitoring efforts of the PCA program to ensure compliance with state and federal requirements.

The Division of Medical Assistance and Health Services (DMAHS), within the DHS, administers New Jersey's Medicaid program. Medicaid is a program through which individuals with disabilities and/or low incomes receive medical assistance. DMAHS contracts with five Managed Care Organizations (MCOs), including WellCare, to provide healthcare services to New Jersey's Medicaid population.

OSC and WellCare conducted a joint audit of HCHC, a PCA/Homemaker provider located in North Brunswick, New Jersey. HCHC enrolled in the Medicaid program as a PCA/Homemaker provider on February 9, 2014. HCHC provides services such as personal care, household duties, and health related tasks performed by a qualified individual in a recipient's place of residence.

Objective

The objective of this audit is to evaluate HCHC's PCA claims billed to and paid by WellCare to determine whether HCHC complied with Medicaid requirements under state and federal laws and regulations.

Scope

The scope of this audit includes a review of paid and adjusted claims billed to WellCare under HCPCS codes S9122, S5130, and T1019 for the period July 1, 2014 through December 31, 2014. The audit was conducted under the authority of *N.J.S.A. 52:15C-23* and the Medicaid Program Integrity and Protection Act *N.J.S.A. 30:4D-53 et seq.*

Audit Methodology

OSC's audit methodology consists of the following:

- Review of 798 claims totaling \$61,196.16 that HCHC submitted for payment to WellCare; and
- Review of HCHC's clinical records to determine whether: PCA services were rendered; PCA services were authorized by the attending physician; PCA services

were prior authorized by WellCare; a Registered Nurse conducted an in-home evaluation of the plan of care at a minimum of once every 60 days; and, PCA services were rendered by licensed providers, and by providers not excluded/debarred from the Medicaid program.

Audit Findings

Duplicate Billing

OSC reviewed the clinical records for the 798 claims to determine whether services that HCHC billed to WellCare were rendered. OSC found that 36 of the 798 claims were duplicates as HCHC billed twice for the same service, once using HCPCS code S5130 and once using HCPCS code S9122. Providers are required to bill and submit claims based on true, accurate and complete information.

Pursuant to *N.J.A.C. 10:49-9.8(a)*, "providers shall certify that the information furnished on the claim is true, accurate, and complete."

Valid Physician Order Not Maintained

OSC reviewed the clinical records for the 798 claims to determine whether services were authorized for the recipient by a physician's order that was signed and dated by the physician. OSC found that 12 of the 798 claims included a physician's order that was signed by a physician's assistant, but not a physician. A properly signed and dated physician's order authorized for the recipient by a physician is necessary to ensure that the services are medically necessary and appropriate. If a physician's order is not authorized by a physician, it is difficult to ensure the services were properly authorized and medically necessary and appropriate.

Pursuant to *42 CFR 440.167(a)*, PCA services are "services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease." The services are "authorized for the individual by a physician and in accordance with a plan of treatment." In accordance with *N.J.A.C. 10:49-5.5(a)(17)*, services that are not covered by the Medicaid program include, "claims for services, goods or supplies which are furnished, rendered, prescribed or ordered in violation of federal or state civil or criminal statutes, or in violation of licensure statutes, rules and/or regulations." Also, in accordance with *N.J.A.C. 10:49-9.8(a)*, "providers shall certify that the information furnished on the claim is true, accurate, and complete."

Unsubstantiated Services Billed

OSC reviewed the clinical records for the 798 claims to determine whether the services that HCHC billed to WellCare were rendered. OSC compared the number of hours billed according to the assignment sheet (timesheet) to HCHC's paid claims data. OSC found that for 6 of the 798 claims, HCHC billed for more hours of service than were rendered

on the dates of service based on HCHC's timesheets. Providers are required to bill and submit claims based on true, accurate and complete information.

Pursuant to *N.J.A.C. 10:49-9.8(a)*, "providers shall certify that the information furnished on the claim is true, accurate, and complete."

In-Home Evaluation of Plan of Care Not Timely Performed

OSC reviewed the clinical records for the 798 claims to determine whether HCHC completed the in-home evaluation of the plan of care at least once every 60 days. OSC found that 5 of the 798 claims failed because HCHC's records did not show that HCHC satisfied this requirement. Specifically, there was no in-home evaluation of the plan of care in the medical record for the dates of service. Timely completion of the in-home evaluation of the plan of care is required to ensure that the plan of care is appropriate and, if not, to make any necessary changes thereto. Since a recipient's needs are subject to change, the plan of care is subject to change as well.

Pursuant to *N.J.A.C. 13:45B-14.9(2)(g)*, "the health care practitioner supervisor shall make an on-site, in-home evaluation of the plan of care not less than once during each 60 day period during which the agency has placed or referred a health care practitioner in the home care setting." In accordance with *N.J.A.C. 10:49-5.5(a)(17)*, services that are not covered by the Medicaid or NJ FamilyCare-Plan A program include, "services, goods or supplies which are furnished, rendered, prescribed or ordered in violation of federal or state civil or criminal statutes, or in violation of licensure statutes, rules and/or regulations." Also, in accordance with *N.J.A.C. 10:49-9.8(a)*, "providers shall certify that the information furnished on the claim is true, accurate, and complete."

Undocumented Services

OSC reviewed the clinical records for the 798 claims to determine whether services that HCHC provided were adequately documented in the medical record. OSC found that 1 of the 798 claims did not meet the appropriate documentation requirements. Specifically, for one of the claims reviewed there was no assignment sheet (timesheet) in the medical record. Assignment sheets not only ensure that services were rendered to the recipient but also validate that services were in fact received by the recipient. Pursuant to *N.J.A.C. 10:49-9.8(a)*, "providers shall certify that the information furnished on the claim is true, accurate, and complete."

Summary of Overpayments

Based on its review, OSC determined that 60 of the 798 HCHC claims for Medicaid reimbursement failed to comply with applicable requirements. On this basis, OSC determined that HCHC received an overpayment of \$4,648.40 for these 60 claims.

Recommendations

OSC recommends that HCHC reimburse Medicaid the overpayment amount, which is \$4,648.40. Also, OSC recommends that HCHC prepare a Corrective Action Plan (CAP) informing OSC of the procedures it will undertake to correct the deficiencies identified in this report. As part of its CAP, HCHC must provide training to its staff to foster compliance with applicable Medicaid regulations, specifically those regarding Medicaid program documentation.

HCHC Response

In a written response, HCHC agreed with the audit findings and provided a CAP to address the audit's recommendations. HCHC also described the specific steps they have taken or will take to implement the recommendations made in this audit report. The full text of the response letter submitted by HCHC is included as an Appendix to this report.

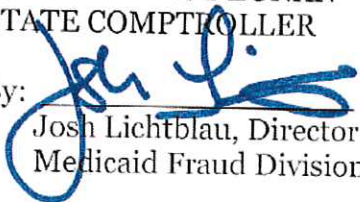
OSC Comments

OSC notes that HCHC is in complete agreement with the audit's findings and recommendations. Accordingly, OSC requests that HCHC reimburse the Medicaid program \$4,648.40 and that it implement the corrective actions needed to comply with the recommendations in this audit. Given HCHC's agreement with the findings in this audit and its stated intention to implement corrective actions, OSC believes that no further action is necessary with respect to this audit.

Sincerely,

PHILIP JAMES DEGNAN
STATE COMPTROLLER

By:


Josh Lichtblau, Director
Medicaid Fraud Division

Cc: Lori Peters, Senior Director, Special Investigations Unit (WellCare)
Jennifer Jarke, Manager, Special Investigations Unit (WellCare)
Kay Ehrenkrantz, Deputy Director
Don Catinello, Supervising Regulatory Officer
Glen Geib, Recovery Supervisor



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Philip James Degnan
State Comptroller
Medicaid Fraud Division
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Trenton, NJ 08625-0025

Re. Draft Audit Report: Health and Comfort Home Care Agency
[REDACTED]

June 4, 2018

Mr. Degnan

This letter will confirm that we agree with the findings of the above Draft Audit report. At the same time, we assure you that any findings that were found were made in error and without any intent to commit fraud nor to increase payments. In fact, even prior to the Audit report our Agency started to take corrective action to avoid any further discrepancies from taking place, as listed below.

Duplicate Billing-In order to avoid potential duplicate billing, we have implemented the following corrective action. We initially had some duplicate codes when servicing Global Options and they have all been eliminated which will prevent this from reoccurring. We have also implemented electronic payments and if we receive direct deposit as a duplicate payment it will show in our system as unapplied cash and we will immediately be aware of the problem and take the necessary corrective action.

Valid Physician's Order Not Maintained-We have already implemented that our Director of Nursing and nurses check more carefully to assure that all physician's orders are properly signed and dated by a physician only to assure that services are medically necessary and appropriate.

Unsubstantiated Service Billed and Undocumented Services- We now have several checkpoints to assure CHHA time sheets and names are matched to master/patient schedule daily for accuracy. We also do Quality Assurance checks by phone and on-site visits to assure services are provided as per time sheets, and master/patient schedule. We also carefully check the filing of time sheets by proper name and hours worked and approved. In addition, with the near future implementation of electronic verification this will further alleviate mistakes such as this taking place.

In-Home Evaluation of Plan of Care Not Timely Performed- The following corrective action has been taken. Medical records are reviewed by RN Supervisor and DON. The plan of care is reviewed at initial assessment, at 6-month reassessment, when the plan of care is updated to reflect any changes in patient's status during each monitoring visit and more frequently if necessary. In addition, we have already implemented whereby the Director of Nursing audits patient records quarterly or more frequently to assure that all records are reviewed by an RN supervisor. Case coordinators document in a centralized data base all changes so that the RN will conduct a reassessment and review of the plan of care changes.

Please note all our staff are aware of the changes we made and have been in-serviced on a regular basis to avoid these issues from reoccurring. Please let us know to whose attention and to whom to make out the check for the overpayment amount of \$4648.40 so that we may process it as soon as possible. We thank you for bringing these matters to our attention.

Sincerely,

William Miska
Administrator

Cc: Michael M. Morgese, Audit Supervisor Medicaid Fraud Division

RECEIVED JUN 06 2018